Forum

Health sector workshops

On 21 July 1996 the Trade Practices Act was due to be extended to cover all in business.

This extension of jurisdiction to unincorporated business results from the bipartisan acceptance of the Hilmer Report by the Council of Australian Governments (COAG); the signing and implementation of the Conduct Code and Competition Principles Agreement by Commonwealth, State and Territory Governments; and the subsequent passing of State and Territory legislation which has the effect of extending Part IV prohibitions to areas of the economy previously outside the scope of Part IV of the Trade Practices Act.

In preparation for the extension of jurisdiction, the Commission has conducted an education campaign over the last 12 months to highlight to those covered for the first time, including many self-employed professionals, their obligations and responsibilities under the Trade Practices Act. A major focus of the campaign has been on the health sector, because of its size and relative importance.

Commission initiatives have included contacting relevant associations to inform them of the need for their articles, codes, by-laws etc. to be amended to comply with the Act; presenting addresses at industry forums; and meeting with various representatives of participants in the sector to discuss issues particular to their members. In November 1995 the Commission published a *Guide to the Trade Practices Act for the health sector*. This publication has been widely distributed.

The culmination of this educational campaign was in May–June 1996 when the Commission presented workshops on the Act to the health sector in all capital cities except Darwin.

One of the primary aims of the workshops was for those attending to gain a better understanding of their and their associations' obligations and rights under the Act. Also it was hoped that they would disseminate the information to their peers and members. Participants included health sector workers and representatives of their associations, private hospital representatives and State government health officials.

General themes that emerged in questions in most capitals were as follows.

- Why can employees and trade unions boycott but professionals cannot?
- How can government departments operate without negotiating with associations for fees for services to the various departments by association members?
- Why do group practices have to stop agreeing on price and how does the Commission see this benefiting consumers?
- How can the Commission judge quality of care, and doesn't the Commission understand that competition will destroy both quality of care and the doctor/patient relationship?

- How can the Commission adjudicate public benefit in this area without participants from the sector assisting?
- Recommended fees — what is acceptable?
- What is the status of conduct currently covered by State legislation?
- Are government business enterprises covered by the Trade Practices Act, and to what extent would the Act apply to the public health system?
- Is the disparity in rebate offered by health funds to practitioners in different States for the same procedure caught by the provisions of the Act?

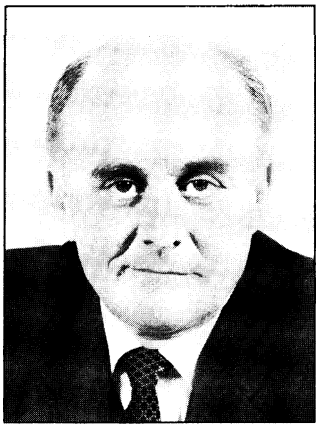
There was also a considerable number of queries on the authorisation process including cost, time to complete, availability of interim authorisation and the nature of public benefit acceptable to the Commission.

Competition in health — a brave new world?

On 10 May 1996 Commission Chairman Professor Allan Fels gave a speech to the Australian Medical Association on the effects of the Trade Practices Act on health providers and the role of the Commission. This speech reflects many of the issues that were discussed at the health workshop. An edited version is provided below.

Role of the Commission and background to the Trade Practices Act

The role of the Commission is to perform the functions conferred upon it by the Trade Practices Act and the Prices Surveillance Act. Among other things, the Trade Practices Act provides the Commission with the duty to enforce compliance with some of its provisions. Enforcement takes place in the Australian court system, and others also have a right of private action. The Commission is able to authorise certain anti-competitive practices which would otherwise breach the Act when it believes that they deliver public benefits which offset the conduct's anti-competitive effects.



The Commission has no law-making role — this belongs to Commonwealth, State and Territory legislatures. The Commission cannot fine those who breach the Act — that is the role of the courts.

The Commission's role as an enforcer depends upon what is and isn't prohibited by the Act. Broadly speaking, Part IV of the Act aims to prevent anti-competitive conduct, thereby encouraging competition and efficiency in business with the result of greater choice for consumers in price, quality and service. In the health sector, this can mean looking at health professionals' conduct to determine whether it promotes or hinders patients' interests in being able to choose among a variety of service and price options according to their needs.

The anti-competitive practices which are prohibited by Part IV are as follows.

- Agreements that have the purpose or effect or likely effect of substantially lessening competition in a market (s. 45).
    - For example, two or more competing hospitals which agree on a market sharing arrangement may be in breach of the Trade Practices Act if the agreement results in a substantial lessening of competition. A specific example would be two private hospitals agreeing that they will each treat patients depending on where the patients live — that is, dividing up the market on the basis of the geographic location of their residence.

- Agreements that contain an exclusionary provision (ss 45, 4D). These are sometimes referred to as primary boycotts and involve competitors agreeing not to deal with another party.
    - For example, if competing specialists in a market area *agree* not to sign contracts with hospitals in the market area they will be in breach of the Trade Practices Act.
- Agreements that have the purpose, effect or likely effect of fixing, controlling or maintaining prices (s. 45A).
    - For example, if competing doctors, hospitals or health funds collude on price, they are deemed to be in breach of the Trade Practices Act.
- Secondary boycotts — that is, action by two or more people which hinders or prevents a third person from supplying goods or services to a business, acquiring goods or services from a business or engaging in interstate trade or commerce where this substantially lessens competition (s. 45D).
    - This provision is often used in industrial disputes but has wider implications. For example, two or more anaesthetists who act in concert to prevent a surgeon from supplying services to a patient may breach this section if the conduct can be shown to substantially lessen competition. I note that the current Government proposes to amend this provision to remove the exemption which applies to 'boycott conduct' within the meaning of the *Industrial Relations Act 1988.*
- Misuse of market power — that is, taking advantage of a substantial degree of power in a market for the purpose of eliminating or substantially damaging a competitor, preventing the entry of a person into any market or deterring or preventing a person from engaging in competitive conduct in any market (s. 46).
- Exclusive dealing — that is, one person who trades with another imposing restrictions on the other's freedom to choose with whom, or in what, to deal (s. 47).
    - For example, if a medical equipment supplier with a unique instrument demands as a condition of supply that a hospital purchases further products from its range, this conduct would be a breach of the Trade Practices Act if it could be shown that it resulted in a substantial lessening of competition. If the same supplier demanded as a condition of supply that the hospital purchased other products from a *third manufacturer*, that conduct is known as third line forcing and is *deemed* to be a breach of the Trade Practices Act. So, in that case, a substantial lessening of competition *would not* need to be established.
- Resale price maintenance — that is, suppliers specifying the minimum price to a reseller (ss 48, 96–100).
    - For example, if pharmaceutical suppliers specify a minimum price below which goods cannot be sold or advertised they will breach the Trade Practices Act.
- Mergers which have the effect, or likely effect, of substantially lessening competition (s. 50).

As mentioned earlier, the Commission is able to authorise anti-competitive conduct that would otherwise be prohibited with the exception of the misuse of market power. Authorisation is available where the conduct in question can be shown to result in a public benefit that outweighs its anti-competitive effect.

Penalties imposed by the courts on parties that breach Part IV of the Trade Practices Act are monetary penalties, with maximums of $10 million for corporations and $500 000 for individuals. The courts can also order injunctions and damages. As mentioned, court action may be taken by the Commission or by private parties (including doctors, health insurers and hospitals).

Part V of the Act safeguards the position of consumers in their dealings with producers and sellers and prohibits conduct which is misleading or deceptive. For example, in November 1995, following Commission action, MBF issued corrective advertising and sent letters to its members retracting false statements made in previous letters sent to members in South Australia, New South Wales and Queensland. The nature of the misleading information in the letters was that they suggested that legislative changes (namely the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995*) required all members of MBF to transfer to 100 per cent hospital cover by July 1997. This requirement to transfer was actually a policy decision of MBF and is not a requirement of the Amendment Act. MBF also gave the Commission court enforceable undertakings which included an undertaking to implement a trade practices compliance program for its staff.

Extended reach of the TPA

The Trade Practices Act is a Commonwealth Act and has therefore been limited in its reach by the Constitution. While the consumer protection provisions in Part V are mirrored by State and Territory legislation, the competition rules in Part IV of the Act have not applied until now to non-corporate organisations which aren't engaged in interstate trade or commerce.

However, at the meeting of the Council of Australian Governments last year, State and Territory Governments agreed to extend Part IV of the Act to apply to State and Territory business activities previously not subject to the Act and unincorporated businesses from 21 July 1996. From 21 July 1997, those who are newly covered by Part IV (with the exception of the Crown) face monetary penalties from the courts for engaging in anti-competitive conduct. In the meantime, courts may impose injunctions and award damages.

Potential areas of legislative review

By itself, the extended reach of Part IV may not address some of the key competition areas identified by Professor Hilmer in his report to COAG. Section 51(1) of the Trade Practices Act exempts anti-competitive conduct which is specifically authorised by Commonwealth, State or Territory law.

In the health sector, anti-competitive conduct which has been specifically authorised by State, Territory or Commonwealth legislation would include the Medicare legislation, Commonwealth legislation governing the conduct of health funds and the Pharmaceutical Benefits Scheme, State and Territory legislation governing hospitals, and State and Territory legislation restricting advertising and other competitive conduct by professionals. State and Territory Governments have agreed to review all legislation, including health legislation, with a view to removing anti-competitive provisions. There are substantial cash incentives for State and Territory Governments to do this and the timetable for review extends to the year 2000.

It is not the role of the Commission to provide policy advice to State, Territory or Commonwealth Governments in relation to the anti-competitive nature of existing legislation — that is one of the functions of an independent body named the National Competition Council (NCC). The Commission will, however, provide information about the operation of the Act to Commonwealth, State and Territory Governments when requested to do so. Neither is it the role of the Commission to monitor the review process — that is the role of the NCC and Treasury.

As well as the removal of the anti-competitive impediments currently protected by State and Territory legislation which prevent fair, equitable and informed marketplaces, the Commission believes that many State Boards should have demand side input. The Commission acknowledges that some State Boards already have consumer representatives as members.

Health care industry and the Trade Practices Act

Since the current Act was proclaimed in 1974, the Commission has been involved in numerous investigations and litigation relating to health service providers to the extent that the law covered health services.

One of its earliest investigations involved a boycott of Canberra hospitals by Canberra doctors. A few years ago the Commission took court action against five of Tasmania's six health funds for an alleged anti-competitive arrangement to attempt to stop the State's private hospitals from discounting their fees for Commonwealth repatriation patients.

As coverage of the Act is extended, it will be important for all involved in the health care industry to understand their obligations, rights and responsibilities under it. However, participants should not be uneasy about the effects of the extension of the Act to the health care industry. The Act is not designed to harm business or prevent fair and fierce competition — in fact it protects both consumers and business from unlawful anti-competitive conduct and unfair market practices.

Competition issues in health care

On 29 May 1995 the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995* became law. Although there has been discussion and speculation following the change of government as to its possible repeal and/or amendment, it remains in force. Many competition and consumer issues arise as a result of this legislation.

This legislation sets in place complex provisions in the way private health insurance is conducted in Australia with wide ramifications for the three key players — health insurance funds, private hospitals, and medical practitioners including specialists.

The legislation provides that individual health funds will become the purchasers of hospital and medical services and will then market these services to patients/consumers.

It is anticipated that health funds will negotiate contracts with hospitals for a particular casemix; this has been the scenario in Victoria for some time. As well, health funds may negotiate with doctors to provide services at a contracted rate.

Boycotts

Some reports indicate that certain doctors or hospitals may refuse to negotiate with funds. Will this action be caught by the provisions of the Act?

The answer to this is no, but only if the doctor or hospital *individually* decides not to negotiate. However, if doctors or private hospitals *jointly* agree not to negotiate, this action may be caught by the primary boycott provisions of the Trade Practices Act. Authorisation is available for this conduct should the public benefits outweigh the anti-competitive detriment.

Similarly the Commission would look closely at refusal to negotiate if such refusal by individual doctors followed or resulted from meetings of doctors at which such conduct was endorsed.

Inducing a contravention — (boycott)

Under the Trade Practices Act the courts can impose penalties and grant injunctions against a person who induces or attempts to induce (whether by threats, promises or otherwise) another person to contravene a provision of Parts IV, IVA or V of the Act. This may have some relevance in relation to the conduct of some health professionals or associations in relation to the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995*.

For example, if a health professional or association attempted to induce other professionals not to sign contracts, where such collective refusal could amount to a primary boycott as proscribed by the Trade Practices Act, such conduct would be at risk of an injunction or penalty. The particular facts and

context of the conduct would need to be looked at closely.

Issues for health professionals

Will the Trade Practices Act allow the AMA or other associations to negotiate on behalf of their members with the various health funds, private hospitals or the Private Hospitals Association?

The answer to this is *no*, unless the joint negotiation position is authorised by the Commission. The Commission would be hesitant to authorise such joint negotiation if the negotiation were proposed on an Australian or State basis. I say *probably* no, as each issue is judged on its facts and these may have different results in different markets.

Joint negotiation may be more acceptable for smaller groups, but for authorisation to be granted, real public benefit has to be shown and this benefit must outweigh the detrimental effect on competition. One, however, would have to query what public benefit would flow from such an arrangement.

Without authorisation, health professionals who jointly negotiate with health funds or hospitals are likely to be in breach of s. 45A, the price fixing provision.

Issues for private hospitals

Private hospital negotiations with health funds for the provision of hospital services need to be completed on an individual basis to ensure there is no risk of breaching the Act. Hospitals that compete with each other, or are in a position to compete with each other, cannot collectively negotiate on price with health funds (nor can they appoint a negotiator) without risking breaching the price fixing provisions of the Act.

Private hospitals, however, have slightly more flexibility in dealings with health professionals to the extent that a group of private hospitals that enters into an agreement to collectively acquire health services would not generally be considered to be price fixing (through the collective acquisition exemption in s. 45A(4)).

However, note that the definition of collective acquisition is generally considered to require collective negotiation and individual acquisition at the negotiated price. Agreements between private hospitals that relate to the prices for their acquisition of services not falling within that definition could be considered to be price fixing.

However, in the event of private hospitals not being covered by s. 45A, the Act still requires an assessment as to whether the agreement has the purpose or effect of substantially lessening competition. If so, it breaches s. 45. This is likely to preclude a group of private hospitals with a combined significant share in the market from entering into such arrangements as it is likely that the agreement would have the effect of substantially lessening competition.

Private hospitals also need to be aware that arrangements or agreements with other private hospitals that don't directly focus on price still may have anti-competitive effects. Into this category fall such things as market sharing agreements and boycotts.

Issues for health funds

The least risk option for health funds in setting premiums for health insurance or in negotiations with hospitals or health professionals is to act unilaterally. Discussing rates of reimbursement with other health funds automatically places the organisation at risk of breaching the price fixing provisions of the Act. Particular collective arrangements may, in some limited circumstances, be possible and these are discussed below.

Health funds acquire services from hospitals and/or health professionals and may therefore be able, as a group, to collectively acquire some of those services. However, the exemption that collective acquisition provides from the price fixing provisions is strictly interpreted by the Commission. Furthermore, a significant grouping of health funds that attempts to effect such a collective acquisition is likely to substantially lessen competition. Any such agreement should not be considered without taking legal advice.

Authorisation for joint negotiation

The authorisation provisions give the Commission the power to grant immunity from legal proceedings for conduct that might otherwise breach the restrictive trade practices provisions of the Act. Decisions of the Commission can be reviewed by application to the Australian Competition Tribunal.

It should be noted that authorisation is a public process, not one conducted privately behind closed doors. The Commission approaches all interested parties to enable them to make submissions on the application for authorisation.

For authorisation to be granted, the applicant must satisfy the Commission that the conduct in question will result in a benefit to the public that outweighs any anti-competitive effect. Thus public benefits are the key in the authorisation process and their articulation should be given careful consideration. Also the benefits must be public, not private.

Public benefits

The Commission and Tribunal have in previous cases recognised the following as public benefits:

- fostering business efficiency, especially when this results in improved international competitiveness;
- industry rationalisation resulting in more efficient allocation of resources and in lower or contained unit production costs;
- promotion of industry cost savings resulting in contained or lower prices at all levels in the supply chain;
- promotion of competition in industry;
- promotion of equitable dealings in the market;
- growth in export markets and development of import replacements;
- assistance to efficient small business, for example guidance on costing and pricing or marketing initiatives which promote competitiveness; and
- industrial harmony.

The long-term viability of a business, however, is usually seen as a private benefit to shareholders even though the public may be disadvantaged should the business fail.

I am aware that smaller hospitals and individual health professionals believe the market power of the health funds will lead to grossly unequal bargaining positions if they have to negotiate unilaterally. Thus to counter this position, joint negotiation is called for, they argue.

Whether this can be categorised as a public benefit and, if so, what weight it would carry will depend on the circumstances and Commission staff would need to vigorously test this in the market.

Unconscionable conduct and other remedies

Private hospitals and individual professionals may be able to seek relief from unequal bargaining positions by having recourse to s. 51AA of the Trade Practices Act — the unconscionable conduct provisions.

Associations of health professionals

Associations of health professionals should be aware of their obligations under the Trade Practices Act. The main considerations are as follows.

- Fee setting — associations should ensure that any schedules of fees issued to members are recommended only and that there should be no pressure on members to adhere to the recommended fee. The Commission is of the view that any recommended fee scale which is invariably adhered to by members of an association is a breach of the Act.
- Other restrictions — associations engage in other restrictive conduct that will need to be addressed. Examples are advertising restrictions, restrictions on association and employment, restrictions on the sale of related goods and services, and certain membership restrictions. State and Territory legislation currently allows some restrictions. However, association officials should ensure that their by-laws etc. do not contain restrictions which extend beyond those currently exempted from Trade

Practices Act coverage by State and Territory law. Any restriction not specifically covered by State and Territory legislation will be examinable under the provisions of the Trade Practices Act. Finally, in the interest of equity and fairness, associations should ensure that disciplinary procedures are subject to review by an independent arbitrator.

The Commission strongly urges association officials to seek independent legal advice and guidance on their particular situations.

Specialist colleges

The Commission has undertaken inquiries in this area. A letter has been sent to all colleges requesting information and documents. I understand some colleges are in the process of reviewing their procedures and Commission staff have offered advice and guidance. However, the onus is squarely on the colleges to review their procedures to comply with the Trade Practices Act. I also urge colleges to seek independent legal advice.

The Commission is also examining entry requirements by colleges to ensure that any restrictions are not anti-competitive.